Child Fatality Report

Report Identification Number: SV-21-054

Prepared by: New York State Office of Children & Family Services

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This report, prepared pursuant to section 20(5) of the Social Services Law (SSL), concerns:

☐ A report made to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) involving the death of a child.

☒ The death of a child for whom child protective services has an open case.

☐ The death of a child whose care and custody or custody and guardianship has been transferred to an authorized agency.

☐ The death of a child for whom the local department of social services has an open preventive service case.

The Office of Children and Family Services (OCFS) is mandated by section 20 of the SSL to investigate or cause for the investigation of the cause and circumstances surrounding the death, review such investigation, and prepare and issue a fatality report in regard to the categories of deaths noted above involving a child, except where a local or regional fatality review team issues a report, as authorized by law.

Such report must include: the cause of death; the identification of child protective or other services provided or actions taken regard to such child and child's family; any extraordinary or pertinent information concerning the circumstances of the child's death; whether the child or the child's family received assistance, care or services from the social services district prior to the child's death; any action or further investigation undertaken by OCFS or the social services district since the child's death; and as appropriate, recommendations for local or state administrative or policy changes.

This report contains no information that would identify the deceased child, his or her siblings, the parent, parents, or other persons legally responsible for the child, and any members of the deceased child's household.

By statute, this report will be forwarded to the social services district, chief county executive officer, chairperson of the local legislative body of the county where the child died and the social services district that had legal custody of the child, if different. Notice of the issuance of this report will be sent to the Speaker of the Assembly and the Temporary President of the Senate of the State of New York.

This report may **only** be disclosed to the public by OCFS pursuant to section 20(5) of the SSL. **It may be released by OCFS only after OCFS has determined that such disclosure is not contrary to the best interests of the deceased child's siblings or other children in the household.**

OCFS' review included an examination of actions taken by individual caseworkers and supervisors within the social services district and agencies under contract with the social services district. The observations and recommendations contained in this report reflect OCFS' assessment and the performance of these agencies.

Abbreviations

Relationships		
BM-Biological Mother	SM-Subject Mother	SC-Subject Child
BF-Biological Father	SF-Subject Father	OC-Other Child
MGM-Maternal Grand Mother	MGF-Maternal Grand Father	FF-Foster Father
PGM-Paternal Grand Mother	PGF-Paternal Grand Father	DCP-Day Care Provider
MGGM-Maternal Great Grand Mother	MGGF-Maternal Great Grand Father	PGGF-Paternal Great Grand Father
PGGM-Paternal Great Grand Mother	MA/MU-Maternal Aunt/Maternal Uncle	PA/PU-Paternal Aunt/Paternal Uncle
FM-Foster Mother	SS-Surviving Sibling	PS-Parent Sub
CH/CHN-Child/Children	OA-Other Adult	
Contacts		
LE-Law Enforcement	CW-Case Worker	CP-Case Planner
Dr.-Doctor	ME-Medical Examiner	EMS-Emergency Medical Services
DC-Day Care	FD-Fire Department	BM-Biological Mother
CPS-Child Protective Services		
Allegations		
FX-Fractures	II-Internal Injuries	L/B/W-Lacerations/Bruises/Welts
S/D/S-Swelling/Dislocation/Sprains	C/T/S-Choking/Twisting/Shaking	B/S-Burns/Scalding
P/Nx-Poisoning/ Noxious Substance	XCP-Excessive Corporal Punishment	PD/AM-Parent's Drug Alcohol Misuse
CD/A-Child's Drug/Alcohol Use	LMC-Lack of Medical Care	EdN-Educational Neglect
EN-Emotional Neglect	SA-Sexual Abuse	M/FTTH-Malnutrition/Failure-to-thrive
IF/C/S-Inadequate Food/ Clothing/ Shelter	IG-Inadequate Guardianship	LS-Lack of Supervision
Ab-Abandonment	OTH/COI-Other	
Miscellaneous		
IND-Indicated	UNF-Unfounded	SO-Sexual Offender
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence
LDSS-Local Department of Social Service	ACS-Administration for Children's Services	NYPD-New York City Police Department
PPRS-Purchased Preventive Rehabilitative Services	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	COS-Court Ordered Services
OP-Order of Protection	RAP-Risk Assessment Profile	FASP-Family Assessment Plan
FAR-Family Assessment Response	Hx-History	Tx-Treatment
CAC-Child Advocacy Center	PIP-Program Improvement Plan	yo- year(s) old
CPR-Cardiopulmonary Resuscitation	ASTO-Allowing Sex Abuse to Occur	

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 4 year(s)
Jurisdiction: Westchester
Gender: Female
Date of Death: 12/10/2021
Initial Date OCFS Notified: 12/16/2021

Presenting Information

A completed 7065 Reporting Form was received which stated the four-year-old subject child died due to complications with a lifelong genetic disorder. The fatality occurred during an ongoing Child Protective Services investigation.

Executive Summary

This fatality report concerns the death of a four-year-old female subject child that occurred on 12/10/21. On 12/16/21, after learning of the fatality, Westchester County Department of Social Services (WCDSS) submitted a completed 7065 Reporting Form to OCFS, which noted the subject child died as a result of a genetic disorder she had since birth. The child's death occurred during a open Child Protective Services investigation, which was addressing concerns the subject child sustained a fractured clavicle while in the care of her parents. This fracture was determined to be a result of the child's many medical conditions associated with her genetic abnormality. Following the subject child's death, it was unknown if an autopsy was completed; however, the child's pediatrician informed WCDSS that the cause of death was pneumonia and syncytial virus, along with complications of Trisomy 18.

At the time of the subject child's death, she resided with her mother, father, and two-year-old surviving sibling. The subject child was nonverbal and immobile. Information obtained by WCDSS noted the child was admitted to the hospital on 12/7/21, after the mother thought the child suffered a seizure. The mother informed WCDSS that tests were being completed, and the doctors felt the child had a respiratory illness. On 12/16/21, the mother informed WCDSS that the subject child had died on 12/10/21 while she was still hospitalized.

WCDSS gathered information surrounding the fatality from family members and collateral sources. The surviving sibling was assessed and deemed safe in the care of his parents. WCDSS offered services to the family and found no evidence to suggest the subject child had been maltreated or abused in any way. WCDSS unsubstantiated the allegations against the parents and closed the investigation.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Safety assessment due at the time of determination?** N/A

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** N/A
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Explain:
This was not an SCR reported fatality.

Was the decision to close the case appropriate? Yes

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? Yes

Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:
The case record reflected supervisory consultations throughout the investigation. The level of casework activity was commensurate with the case circumstances.

Required Actions Related to the Fatality

Are there Required Actions related to the compliance issue(s)? ☐ Yes ☒ No

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 12/10/2021 **Time of Death:** Unknown

Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Bronx
Was 911 or local emergency number called? No
Did EMS respond to the scene? No
At time of incident leading to death, had child used alcohol or drugs? No
Child's activity at time of incident:

- ☐ Sleeping
- ☐ Working
- ☐ Driving / Vehicle occupant
- ☐ Playing
- ☐ Eating
- ☐ Unknown
- ☒ Other: Hospitalized.

Did child have supervision at time of incident leading to death? Yes
At time of incident was supervisor impaired? Unknown if they were impaired.
At time of incident supervisor was:

- ☐ Distracted
- ☐ Absent
- ☐ Asleep
- ☐ Other:

Total number of deaths at incident event:
Children ages 0-18: 1
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age

Deceased Child's Household	Deceased Child	No Role	Female	4 Year(s)
Deceased Child's Household	Father	No Role	Male	34 Year(s)
Deceased Child's Household	Mother	No Role	Female	32 Year(s)
Deceased Child's Household	Sibling	No Role	Male	2 Year(s)

LDSS Response

On 12/20/21, OCFS received the 7065-reporting form regarding the death of SC, which occurred on 12/10/21. At the time of the fatality, the family had been involved in an active CPS investigation which was initiated on 11/19/21. This investigation was regarding a report received with concerns SC sustained a fractured right clavicle and the injury was suspicious.

It was learned SC suffered from a genetic disorder since birth that caused an array of medical conditions, including susceptibility to bone fractures. During the investigation, medical professionals ruled out any abuse or maltreatment regarding the broken clavicle and noted all of SC's ailments were due to her condition. WCDSS was informed by SC's providers that BM and BF diligently followed through with SC's numerous medical recommendations and treatments. BM and BF were interviewed, the family's home was observed, and the safety of the SS was assessed. There were no concerns noted and SS was deemed safe in the care of his parents.

WCDSS was in frequent contact with the family throughout the CPS investigation, and on 12/7/21 spoke with BM via phone. BM explained SC had been whining and began shaking and she did not know if it was a seizure, so she brought SC to the hospital where she was admitted. On 12/8/21, BM spoke again with WCDSS and explained the doctors thought SC had a cold, because the tests they ran did not come back with anything concerning. The next time WCDSS had contact with the family was on 12/16/21, when BM informed WCDSS that SC had died in the hospital on 12/10/21. BM reported the doctors finally realized the issue was with SC's heart "but she ended up dying."

WCDSS made several attempts to obtain medical records regarding SC's most recent hospital stay and the death; however, the hospital's health information management representative did not fulfill the requests.

On 12/17/21, WCDSS spoke with the children's pediatrician, who reported both SC and SS were well cared for, and he had no concerns regarding the parents. The pediatrician further explained he was made aware SC died from pneumonia while hospitalized, and that with SC's medical condition, most children will die before the age of 1. The doctor reported SC's health began to deteriorate in March 2021 due to the condition, and not from abuse or maltreatment. On this same date, WCDSS again assessed the safety of the SS, and there were no concerns. Services were offered to the family but declined. There was no evidence to support the allegations that were received in the CPS report, and WCDSS gathered all available information related to the fatality. There was no reasonable cause to suspect BM or BF had any role in the death of SC, and therefore, the case was unfounded closed.

Official Manner and Cause of Death

Official Manner: Natural
Primary Cause of Death: From a medical cause
Person Declaring Official Manner and Cause of Death: Unknown

Multidisciplinary Investigation/Review

Was the fatality referred to an OCFS approved Child Fatality Review Team? Yes

Comments: This fatality was submitted for review by the Westchester Child Fatality Review Team.

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☐	☐	☒	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☐	☐	☒	☐
Coordination of investigation with law enforcement?	☐	☐	☒	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:
WCDSS interviewed the family and appropriate collateral sources. Progress notes and other documentation were completed and entered timely.

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☐	☐	☒	☐
At 7 days?	☐	☐	☒	☐
At 30 days?	☐	☐	☒	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☐	☐	☒	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

When safety factors were present that placed the surviving siblings/other children in the household in impending or immediate danger of serious harm, were the safety interventions, including parent/caretaker actions adequate?	☐	☐	☒	☐
Explain: This was not an SCR reported fatality, therefore, safety assessments were not required.				

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	☐	☐	☒	☐
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	☐	☐	☒	☐
Was there an adequate assessment of the family's need for services?	☒	☐	☐	☐
Did the protective factors in this case require the LDSS to file a petition in Family Court at any time during or after the investigation?	☐	☒	☐	☐
Were appropriate/needed services offered in this case	☒	☐	☐	☐
Explain: This was not an SCR reported fatality, therefore, a Risk Assessment Profile was not required.				

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?	☐	☒	☐	☐
Were there surviving children in the household that were removed either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☐	☒	☐	☐
Explain as necessary: The surviving sibling did not need to be removed as a result of this fatality.				

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation? There was no legal activity.

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A	CDR Lead to Referral
Bereavement counseling	☐	☒	☐	☐	☐	☐	☐
Economic support	☐	☐	☐	☐	☐	☒	☐
Funeral arrangements	☐	☒	☐	☐	☐	☐	☐
Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☐	☒	☐	☐	☐	☐	☐
Foster care	☐	☐	☐	☐	☐	☒	☐

Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☐	☐	☐	☐	☒	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐
Alcohol/Substance abuse	☐	☐	☐	☐	☐	☒	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☐	☐	☐	☐	☐	☒	☐
Other	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
WCDSS offered the family appropriate services in response to the subject child's death; however, services were declined.

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? No
Explain:
WCDSS offered the family services for the sibling following the subject child's death; however, they declined.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
WCDSS offered the family services following the subject child's death; however, they declined.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was the child ever placed outside of the home prior to the death? No
Were there any siblings ever placed outside of the home prior to this child's death? No
Was the child acutely ill during the two weeks before death? Yes

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
11/19/2021	Deceased Child, Female, 3 Years	Mother, Female, 32 Years	Fractures	Unsubstantiated	No

Deceased Child, Female, 3 Years	Mother, Female, 32 Years	Inadequate Guardianship	Unsubstantiated	
Deceased Child, Female, 3 Years	Father, Male, 34 Years	Fractures	Unsubstantiated	
Deceased Child, Female, 3 Years	Father, Male, 34 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
This SCR report was received with concerns the subject child had special needs and was diagnosed with an unexplained fractured right clavicle.

Report Determination: Unfounded | **Date of Determination:** 01/07/2022

Basis for Determination:
WCDSS interviewed family members and collateral sources. It was determined the subject child suffered from a genetic condition that caused severe developmental delays. The child was nonverbal, had no motor skills, and was fed via a feeding tube. The child's disability made her more susceptible to certain infections and fractures specific to the ribs and clavicles. Medical providers had no concerns surrounding the parents' ability to meet the many needs of the subject child. The sibling was also deemed safe with no concerns. The subject child died from complications of her disorder while this investigation was ongoing.

OCFS Review Results:
This investigation met all statutory requirements.

Are there Required Actions related to the compliance issue(s)? ☐ Yes ☒ No

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
03/17/2021	Deceased Child, Female, 3 Years	Mother, Female, 32 Years	Fractures	Unsubstantiated	No
	Deceased Child, Female, 3 Years	Mother, Female, 32 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Female, 3 Years	Mother, Female, 32 Years	Lack of Medical Care	Unsubstantiated	
	Deceased Child, Female, 3 Years	Mother, Female, 32 Years	Swelling / Dislocations / Sprains	Unsubstantiated	
	Deceased Child, Female, 3 Years	Father, Male, 34 Years	Fractures	Unsubstantiated	
	Deceased Child, Female, 3 Years	Father, Male, 34 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Female, 3 Years	Father, Male, 34 Years	Lack of Medical Care	Unsubstantiated	
	Deceased Child, Female, 3 Years	Father, Male, 34 Years	Swelling / Dislocations / Sprains	Unsubstantiated	

Report Summary:
This SCR report was received with concerns that on an unknown date, the subject child sustained a clavicle fracture while in the care of her parents. The explanation provided for the injury was no plausible. The parents noticed swelling over the child's clavicle on 3/16/21 and did not seek immediate medical attention.

Report Determination: Unfounded | **Date of Determination:** 04/28/2021

Basis for Determination:
SC suffered from a genetic condition that made her more susceptible to fractures specific to the ribs and clavicles. BM reported that on 3/14/21, the child was fussy, and on 3/16/21, she appeared to be in pain. BM called the pediatrician on that date and explained SC cried when her left shoulder was touched. The pediatrician told her to monitor SC and attend a scheduled appointment on 3/19/21. On 3/17/21, the pain appeared worse, so BM brought SC to the ER, where the broken clavicle was found. It was determined the fracture was due to SC's thin bones caused by the genetic condition. Providers had no concerns surrounding the parents' ability to meet the needs of SC and SS was deemed safe.

OCFS Review Results:
This investigation met all statutory requirements.

Are there Required Actions related to the compliance issue(s)? ☐Yes ☒No

CPS - Investigative History More Than Three Years Prior to the Fatality

There was no CPS investigative history more than three years prior to the fatality.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation? There was no legal activity.

Recommended Action(s)

Are there any recommended actions for local or state administrative or policy changes? ☐Yes ☒No

Are there any recommended prevention activities resulting from the review? ☐Yes ☒No